CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Fact Sheet
FOR PROVIDER BILLING STAFF

WHEN MEDICARE IS THE PRIMARY PAYER

Background

As the Medicare program matures and the "baby boomer" generation moves towards retirement, it becomes critical to maintain the viability and integrity of the Medicare Trust Fund. Providers can contribute to the appropriate use of Medicare by complying with all Medicare requirements, including those applicable to Medicare Secondary Payer (MSP). The purpose of this Fact Sheet is to provide a general overview for provider billing staff when Medicare is responsible for paying first or is commonly referred to as the primary payer.

What Is Medicare Secondary Payer (MSP)?

"Medicare Secondary Payer" is the term used by Medicare when it is not responsible for paying a claim first. When Medicare began on July 1, 1966, it was the primary payer for all beneficiaries, except for those who received benefits from the Federal Black Lung Program, Workers' Compensation (WC), and those that receive all covered health care services through the Veterans Health Administration (VHA) programs. Beginning in 1980, changes to Medicare laws increased the number of coverage and benefit programs that are primary to Medicare. These changes help to preserve the Medicare Trust Fund and limit the beneficiary's out-of-pocket costs. However, these changes also made the billing process more complex, especially when trying to determine if Medicare is the first or second payer.

When Does Medicare Pay First?

Medicare remains the primary payer for beneficiaries who are not covered by other types of insurance. Medicare is also the primary payer in other instances, provided several conditions are met. Table 1 lists some common situations when Medicare may be the primary or secondary payer for a patient's claims:

Table 1. List of Common Situations When Medicare May Pay First or Second

If the patient…	And this condition exists…	Then this program pays first…	And this program pays second…
Is age 65 or older, and is covered by a Group Health Plan through a current employer or spouse's current employer…	The employer has less than 20 employees…	**Medicare**	Group Health Plan
	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals…	Group Health Plan	**Medicare**
Has an employer retirement plan and is age 65 or older or is disabled and age 65 or older…	The patient is entitled to Medicare…	**Medicare**	Retiree coverage
Is disabled and covered by a Large Group Health Plan from work, or is covered by a family member who is working…	The employer has less than 100 employees…	**Medicare**	Large Group Health Plan
	The empolyer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals…	Large Group Health Plan	**Medicare**
Has end-stage renal disease and Group Health Plan Coverage…	Is in the first 30 months of eligibility or entitlement to Medicare…	Group Health Plan	**Medicare**
	After 30 months…	**Medicare**	Group Health Plan
Has end-stage renal disease and COBRA coverage…	Is in the first 30 months of eligibility or entitlement to Medicare…	COBRA	**Medicare**
	After 30 months…	**Medicare**	COBRA
Is covered under Workers' Compensation because of job-related illness or injury…	The patient is entitled to Medicare…	Workers' Compensation (for health care items or services related to job-related illness or injury)	**Medicare**
Has black lung disease and is covered under the Federal Black Lung Program…	The patient is eligible for the Federal Black Lung Program…	Federal Black Lung Program (for health care services related to black lung disease)	**Medicare**
Has been in an accident where no-fault or liability insurance is involved…	The patient is entitled to Medicare…	No-fault or liability insurance (for accident-related health care services)	**Medicare**
Is age 65 or older OR is disabled and covered by Medicare and COBRA…	The patient is entitled to Medicare…	**Medicare**	COBRA
Has Veterans Health Administration (VHA) benefits…	Receives VHA authorized health care services at a non-VHA facility…	VHA	Medicare may pay when the services provided are Medicare-covered services and are not covered by the VHA

How Do Providers Know When to Bill Medicare First?

To determine if Medicare is the primary payer, providers must ask the beneficiary about any additional coverage that he or she may have. To obtain the most updated information, providers should ask about any other insurance coverage at each patient visit. Some of the suggested questions that providers should ask are:

- Is the patient covered by any Group Health Plan (GHP) through his or her current or former employment? If so, how many employees work for the employer providing coverage?
- Is the patient covered by any GHP through a family member's current or former employment? If so, how many employees work for the employer providing the GHP?
- Is the patient receiving Federal Black Lung Program benefits?
- Is the illness or injury due to a work-related accident or condition, and is it being covered by WC?
- Is the illness or injury covered under automobile insurance, no-fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?
- Is the patient being treated for an injury or illness for which another party could be held liable?

Answers to these questions will help providers complete the claim form and submit it to the correct primary payer. If providers do not submit the correct information to Medicare, Medicare retains the right to recover any mistaken payments made to the provider.

Are There Any Exceptions to MSP Requirements?

In most cases, Federal law takes precedence over state laws and private contracts. Even if a state law or insurance policy states that they are a secondary payer to Medicare, the MSP regulations should be followed when billing for services.

What Happens if the Primary Payer Denies a Claim?

In the following situations, Medicare *may* make payment assuming the services are covered and a proper claim has been filed.

- The GHP denies payment for services because the beneficiary is not covered by the health plan;
- The no-fault or liability insurer does not pay, or denies the medical bill;
- The WC program denies payment, as in situations where WC is not required to pay for a given medical condition; or
- The Federal Black Lung Program will not pay the bill.

In these situations, providers should include documentation from the primary payer stating that the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare.

When Will Medicare Make a Conditional Payment?

A conditional payment is a payment made by Medicare, for Medicare covered services, where another payer is responsible for payment and the claim is not expected to be paid promptly (i.e., within 120 days from receipt of the claim). Medicare makes conditional payments to prevent the beneficiary from using his or her own money to pay the claim. However, Medicare has the right to recover any payments. This includes payments that should have been paid under WC, liability, no-fault insurance, or a GHP.

What Is Medicare Coordination of Benefits (COB)?

Coordination of Benefits (COB) is a CMS effort to identify additional health benefits that a Medicare beneficiary may have, and coordinate the payment process to prevent and minimize mistaken Medicare payments. The

COB Contractor collects, manages, and maintains information on Medicare's Common Working File (CWF) regarding other health insurance coverage for Medicare beneficiaries. The COB Contractor also initiates all MSP claims investigations. The COB Contractor does not process claims and cannot provide information regarding specific claims. Questions about claims should be directed to the local Medicare claims processing contractor.

How Do Providers Contact the COB Contractor?

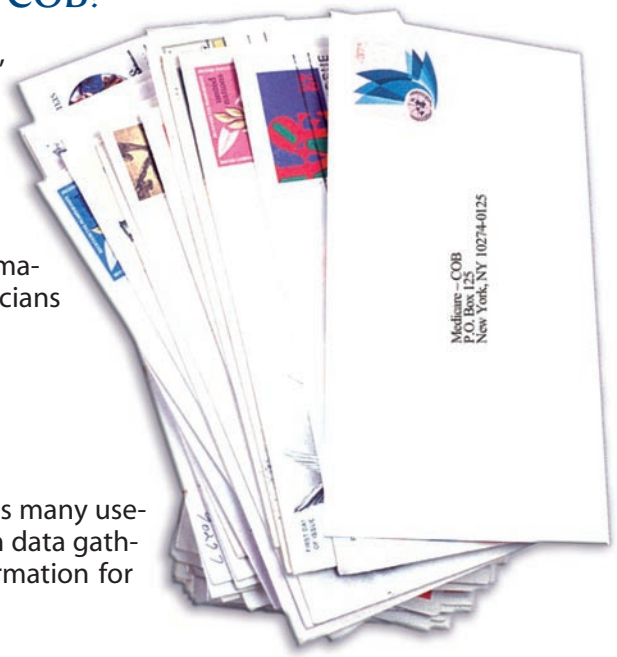
Providers may contact the COB Contractor at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday - Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). Providers may contact the COB Contractor to:

- Report potential MSP situations;
- Report incorrect insurance information; or
- Address general MSP questions/concerns.

Specific claim-based issues (including claim processing) should still be addressed to the provider's Intermediaries and/or Carriers.

Where Can I Find More Information on MSP and COB?

CMS offers several online references for information about MSP, COB, and the Medicare program:



- **The Medicare Learning Network Home Page**

  www.cms.hhs.gov/MLNGenInfo

  The Medlearn Home Page features CMS provider education materials for COB and MSP issues, including a link to the Physicians Information Resource for Medicare Home Page.

- **The Medicare Secondary Payer and You Home Page**

  www.cms.hhs.gov/MedicareSecondPayerandYou/

  The Medicare Secondary Payer and You Home Page contains many useful resources for the MSP Program, including information on data gathering for providers, claims investigations, and contact information for the COB Contractor.

- **The Medicare Coordination of Benefits Home Page**

  www.cms.hhs.gov/ProviderServices/

  The Medicare Coordination of Benefits Home Page features MSP Program materials for providers such as the *COB Contractor Claims Investigation Fact Sheet for Providers* and quarterly newsletters.

Written inquiries or requests for hardcopy COB newsletters can be sent to:

Medicare – COB
P.O. Box 125
New York, NY 10274-0125